. S. No. 2
M—8-43
v. 5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 5 1945

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 7066

Registrar's No. 56

1. **PLACE OF DEATH:**
(a) County St. Louis Co.
(b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Co. Hosp. D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2-23-45 9:30 a.m. – 2-24-45 2:50 P.m. (Specify whether years, months or days)
In this community Life

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County — 000
(c) City ~~or town~~ St. Louis, 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4622 A Evans 9
(If rural, give location)
(e) Citizen of foreign country? no 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BENSON, JAMES W.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male
5. Color or race Col
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Georgia Benson
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased 5 (Month) 20 (Day) 78 (Year)

8. AGE: Years 66 Months 9 Days 4 If less than one day hr. min.

9. Birthplace St. Louis Co (City, town, or county) Mo. D (State or foreign country)
10. Usual occupation Yard man
11. Industry or business
FATHER 12. Name Wm. Benson 9
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mellie Johnson 9
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant Georgia Benson – wife
(b) Address 4622 A Evans, St. Louis, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery
18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Ave.
19. (a) FEB 28 1945 (Date received local registrar) (b) Dr. E. G. McGavran (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 2 day 24 year 1945 hour 2 minute 50 P.M.
21. I hereby certify that I attended the deceased from 2-23-45 9:30 a.m., 19 45, to 2-24 (2:50 P.M.) 19 45; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to Hypertensive C-V disease	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 93d

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature H. Meyer M.D. (M. D. or other)
Address St. Louis Co. Hosp. Date signed 2-24-45

(Licensed Embalmer's Statement on Reverse Side)

MAR 12 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Thomas J. Gates, Registered Apprentice No. _____, working under my personal supervision.

Signed Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address 407 Finney Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.